QUESTIONS PRESENTED

I.

Whether the duty and authority of the Trial Court to instruct a verdict, in a case where the evidence is uncontroverted, should be nullified by decision of the Court of Appeals that a jury trial was proper, when the opinion of the Court of Appeals discloses that its conclusion was not based upon the existence of controverting evidence, but upon mere conjecture and supposition as to the mental processes of the jurors.

II.

Whether the mere fact that a medical doctor was a man of means and bore a good reputation was sufficient evidence to raise a jury issue in a suit upon his life insurance policy, as held by the Court of Appeals herein, when the evidence is undisputed that said doctor fraudulently concealed from the insurance company, prior to the issuance of the policy, the fact that he was then afflicted with a serious malady and that he had previously been examined for same by other doctors with whom he was in continuous consultation, all of which facts were established by the written declarations and communications of the insured doctor himself.

III.

Whether a life insurance company is entitled to rely upon the truthfulness of statements made by a medical doctor in his application for life insurance, when after his

death, six months later, it is discovered that he was afflicted with a serious malady for which he had been examined by other doctors on several occasions, and with whom he was in continuous written consultation about his condition up to the time of making such application, which facts were concealed from the insurance company in the doctor's application for insurance, and which facts were established without controversy by the doctor's own written declarations and letters which came to light after his death.

STATEMENT OF THE CASE

Jurisdiction herein is predicated upon diversity of citizenship of the parties.

This cause was instituted in the United States District Court for the Eastern District of Texas, Tyler Division, by the Respondent, Mrs. Rosa Lee Roosth, a resident of Tyler, Texas, who was the surviving wife of Dr. Harold Roosth, deceased, against the Petitioner, The Lincoln National Life Insurance Company, an Indiana corporation. By this action the Respondent, as beneficiary in a certain policy of insurance issued by the Petitioner on December 24, 1956, to Dr. Harold Roosth as the insured, sought to recover of the Petitioner the sum of $50,000.00 as the proceeds of said policy, together with statutory penalties and attorneys' fees. Petitioner defended said action on the ground that the insured knowingly made several false statements and misrepresentations of fact in his written application for such insurance, with intent to deceive the

Petitioner, which were material and were relied upon by Petitioner in issuing said policy; and on the further ground that inasmuch as Dr. Roosth was not in good health when said policy was issued and delivered, same was ineffective as a contractual obligation.

The insured, Dr. Roosth, died suddenly from a cerebral hemorrhage on February 7, 1957, within six weeks after the issuance of said policy of insurance. (Certificate of Death, Plaintiff's Exhibit No. 7.) The insurance company discovered for the first time, in the course of an investigation it conducted after Dr. Roosth's death, that previously to his application for insurance he had been examined and observed for hypertension by doctors of the Smithwick Clinic in Boston, Massachusetts (R. 712-713). The investigation further developed that Dr. Roosth had been under examination and observation for hypertension by the doctors in the Smithwick Clinic in Boston on three occasions, to-wit, November 15-18, 1950, November 21, 1951, and June 11, 1953. (R. 227; Defendant's Exhibit No. 34.)

In his application for the insurance herein sued for, duly signed by Dr. Roosth (Defendant's Exhibit No. 3, Part 2), he made no disclosure or reference whatever to the fact that he was afflicted with hypertension, nor that he had been examined and observed by the doctors in the Smithwick Clinic for such condition. In answer to direct questions propounded in the application, Dr. Roosth made no mention of the fact that he had been in the Smithwick Clinic for examination, observation and treatment. (Question 13; Defendant's Exhibit No. 3, Part 2.) Nor did he,

in answer to specific questions in the application (Question 14), divulge the names of Dr. Smithwick, Dr. Kinsey, or other doctors of the Smithwick Clinic who had examined him for hypertension on the occasions heretofore mentioned.

In answer to other inquiries in said application for insurance, Dr. Roosth denied that he then "had any disease or disorder" (Question 11). He further stated therein that the cause of the death of his mother was "Childbirth," which was a palpable falsehood. In giving his case history, upon his first visit to the Smithwick Clinic in Boston, Dr. Roosth stated that the cause of his mother's death was "Hypertension" (Defendant's Exhibit No. 18). Likewise, he told Dr. Horwitz, who took his case history in the Massachusetts Memorial Hospital in Boston on November 15, 1950, that the cause of the death of his mother was "Cerebral Vascular Accident" (Defendant's Exhibit No. 17). It is noteworthy that the death of Dr. Roosth himself, as heretofore stated, was incident to a cerebral vacular accident. The Death Certificate of the mother of Dr. Roosth recited that the cause of her death was "Heart Block and Chronic Nephritis" (Plaintiff's Exhibit No. 6). In any event, despite any apparent discrepancies, it is inescapable that the cause of the death of Dr. Roosth's mother was not "childbirth."

The concealment and misrepresentation perpetrated by Dr. Roosth in his application for insurance in the particulars above mentioned are established incontrovertibly by the written declarations and communications of Dr. Roosth

himself. The record contains an exchange of correspondence between Dr. Roosth and Dr. Dera Kinsey and Dr. Reginald H. Smithwick extending over a period of time from November 22, 1950, to January 24, 1957. (Defendant's Exhibits Nos. 20, 4, 30, 5, 32, 7, 33, 7A, 29 and 31.) These communications are unimpeached and establish without contradiction the salient facts that Dr. Roosth was examined, observed and treated by the doctors in the Smithwick Clinic in Boston for "hypertension" on three occasions, and that this exchange of correspondence between said doctors regarding the condition of Dr. Roosth was continued from time to time until two weeks before his death. This unimpeached documentary evidence, together with the hospital and clinic records of the Smithwick Clinic pertaining to Dr. Roosth's examination and observation, made by and under the direction of the insured himself (Defendant's Exhibits Nos. 17, 18 and 34), constituted irrefuted proof supporting Petitioner's contention that Dr. Roosth concealed and misrepresented material facts in his application for insurance.

In his application for the insurance policy involved in this litigation, Dr. Roosth stated, in answer to Question 14(c), that previously he had had a mild heart attack in September, 1948, and that as a result of which he was confined to his bed, at his home in Tyler, Texas, for a period of two months, but that he had had a satisfactory recovery. In consequence of this heart situation, the Petitioner advised Dr. Roosth that it would issue the policy of

insurance only upon an increased premium charge, which was beyond the normal rate (R. 108).

According to the testimony of all of the doctors who testified, the existence of a hypertensive condition in an individual who also has been the subject of a heart attack, greatly aggravates the situation and materially reduces the life expectancy of such individual. Without question this hazardous situation was well known to Dr. Roosth who, himself, was an experienced Doctor of Medicine and a specialist in the field of Internal Medicine, which comprises the treatment and care of persons afflicted with cardio-vascular disturbances, including both heart ailments and hypertension. (R. 537-538.)

Likewise, the evidence is without dispute that if the officials of the Petitioner insurance company who approved Dr. Roosth's application for insurance, had been advised of his hypertensive condition, the policy would not have been issued because of the increased risk thereby occasioned, in conjunction with his history of a heart attack. (R. 458, 468-470, 495, 499.) Furthermore, it is uncontroverted that in approving Dr. Roosth's application for insurance, the officials and agents of the insurance company had no knowledge whatever of the existence of Dr. Roosth's hypertensive condition, nor that he had ever been examined, observed, or treated for such condition by any doctors or in any clinic or hospital. (R. 429, 437, 438, 466, 498-499.)

At the conclusion of the evidence the Petition moved the Trial Court to withdraw the case from the jury and to

instruct the jury to return a verdict in its favor, for the reason that the evidence was so uncontroverted as to raise no jury issue, in that (1) Dr. Roosth knowingly and willfully made false statements in his application for the insurance policy sued upon with the intention of deceiving the Petitioner, which relied thereon and was induced thereby to issue such policy, and (2) at the time such policy was applied for and issued, Dr. Roosth was not in good health (except for the residual effects of a prior heart attack). (R. 18-21.) The Trial Judge declined to grant said motion for directed verdict when same was presented at the close of the evidence, but he submitted the cause to the jury subject to a later determination of the legal questions raised by said motion, as authorized by the provisions of Rule 50(b) of the Federal Rules of Civil Procedure. (R. 738.) After deliberating for an extended period of time, the jury was unable to agree upon a verdict and was discharged by the Court. (R. 757-758.)

As heretofore has been indicated, the Trial Court granted the motion of the Petitioner for judgment, filed in accordance with the provisions of Rule 50(b) of the Federal Rules of Civil Procedure (R. 31-33), and accordingly, judgment was entered in favor of the Petitioner that the Respondent recover nothing by this suit. (R. 31-33.)

An appeal from said judgment having been prosecuted by the Respondent to the Court of Appeals for the Fifth Circuit, and by divided Court of two to one—Chief Judge Hutcheson dissenting—the Court of Appeals ordered that

the judgment of the Trial Court be reversed and the cause be remanded for another trial. (R. 785.)

The opinion of the majority of the Court of Appeals is predicated upon the conclusion that the Trial Court erred in entering judgment in this cause absent jury findings; whereas, Chief Judge Hutcheson, in dissenting, expressed the view that the evidence disclosed no issue properly to be submitted to the jury. (Appendix A, Appendix B, and Appendix C.)

REASONS FOR GRANTING WRIT OF CERTIORARI

I.

The decision of the majority of the Court of Appeals has abridged the authority vested in the Trial Court to direct a verdict when the evidence is so uncontroverted that reasonable minds cannot differ as to its effect; and in rendering such decision, the Court of Appeals has so far departed from the accepted and usual course of judicial proceedings as to call for the exercise of the power of supervision of the Supreme Court.

II.

If it is permitted to remain unchallenged as a judicial precedent, the majority decision of the Court of Appeals places an undue burden upon the life insurance industry in that in consequence thereof the right of a life insurance company to rely upon the truthfulness of the representations made by the insured in the application for insurance is effectively nullified.

III.

The decision of the majority of the Court of Appeals is in direct conflict with other recent decisions of the same Court of Appeals for the Fifth Circuit, viz.:

United States v. Stratton, 232 Fed. 2d 880;

McDaniel v. United States, 196 Fed. 2d 291;

Rhodes v. Metropolitan Life Ins. Co., 172 Fed. 2d 183.

In consequence of the majority opinion in the instant cause, the principles of law announced by the same Court of Appeals in the cases above cited have been cast into a state of serious confusion and uncertainty, which is disparaging not only to the Bench and Bar, but also to litigants, present and future, whose rights may be concerned with similar legal situations.

IV.

The decision of the majority of the Court of Civil Appeals is in conflict with decisions of other United States Courts of Appeals involving the same legal issues, as follows:

McSweeney v. Prudential Ins. Co., 128 Fed. 2d 660, by the United States Court of Appeals for the Fourth Circuit;

Provident Life & Acc. Ins. Co. v. Hawley, 123 Fed. 2d 179, by the United States Court of Appeals for the Fourth Circuit;

Atlantic Life Ins. Co. v. Hoefer, 66 Fed. 2d 461, by the United States Court of Appeals for the Fourth Circuit;

Stewart v. American Life Ins. Co., 89 Fed. 2d 743, by the United States Court of Appeals for the Tenth Circuit.

V.

The decision of the majority of the Court of Appeals is in conflict with the decision of this Honorable Supreme Court in Pence v. United States, 316 U. S. 332, 81 L. Ed. 1510.

VI.

The decision of the majority of the Court of Appeals is in conflict with the applicable law of the State of Texas as is evidenced by the opinions in the following cases:

Clark v. National Life & Acc. Ins. Co. (By the Supreme Court of Texas), 145 Texas 575; 200 S. W. 2d 820;

Texas Prudential Ins. Co. v. Dillard (By the Supreme Court of Texas), Texas ; 307 S. W. 2d 242;

John Hancock Life Ins. Co. v. Esparza (By the Texas Court of Civil Appeals for the Fourth District; Writ of Error refused by the Supreme Court, N.R.E.), 286 S. W. 2d 695.

ARGUMENT

Majority Decision Abridges Right of Trial Court to Direct Verdict

We are well aware of the reluctance of this Honorable Supreme Court to entertain a review of a decision of a Court of Appeals when issues of fact may be involved. May we respectfully urge, however, that the review here sought involves more than a mere determination of the eixstence *vel non* of controverting fact issues necessitating a jury

trial. There is involved herein the fundamental question of an abridgement of the authority and duty of a Trial Court to direct a verdict whenever the evidence is of such conclusive nature as to leave no reasonable doubt as to what the true facts are.

It is the well-settled rule in the Federal Courts that if the Trial Court reaches the conclusion that the evidence is such that if a verdict returned in favor of one party would have to be set aside, the Court may and should direct a verdict for the other party. This principle was announced long ago by the Supreme Court of the United States in *Texas & Pacific Ry. Co. v. Stewart, 228 U. S. 357, 57 L. Ed. 875*, in the following language:

> "As a preliminary to the consideration of the first question it may be well to repeat what this court often has said, that when, on the trial of the issues of fact in an action at law before a Federal court and a jury, the evidence, with all the inferences that justifiably could be drawn from it, does not constitute a sufficient basis for a verdict for the plaintiff or the defendant, as the case may be, so that such a verdict, if returned, would have to be set aside, the court may and should direct a verdict for the other party."

The foregoing pronouncement has been recognized and followed by the Federal Courts through the years. Among some of the decisions which reiterate this principle are the following: *Wright v. Grain Dealers Nat. Mut. Fire Ins. Co. (4th Circuit), 186 Fed. 2d 956;* and *Franks v. Groendyke Transport, Inc. (10th Circuit), 229 Fed. 2d 731.* In the opinion in the latter case, the Court said:

> "But it is the province and duty of the court to direct a verdict where the evidence is without dispute

> or is conflicting but of such conclusive nature that if a verdict were returned for one party the exercise of sound judicial discretion would require that it be set aside."

In *State of Washington v. United States (9th Circuit), 214 Fed. 2d 33 (Certiorari denied, 348 U. S. 862)*, the Court laid down the rule, which is therein recited to be the recognized rule, that "The crux of the matter is whether there is substantial evidence to support the verdict." In defining the term "substantial evidence" the Court refers to the definition that is found in the decision of the Supreme Court of the United States in *Consolidated Ed. Company v. N.L.R.B., 305 U. S. 197, 83 L. Ed.* as follows:

> "Substantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."

There is no need that we be reminded that the Trial Judge, from his vantage point, is in a better position to appraise and evaluate the evidence than anyone else. The fact that he hears the witnesses testify and observes their demeanor on the witness stand, enables him to have a better opportunity to determine whether or not the evidence is such that reasonable minds cannot differ as to its consequences. We sincerely entertain the view that under our system of jurisprudence the Trial Court is vested with a greater degree of discretion in making such determination. As is said in the opinion of the Court of Appeals for

the Ninth Circuit in *State of Washington v. United States*, supra:

> "However, in making the primary determination as to whether or not there is substantial evidence, a district judge is not a mere 'automaton.' He must determine not whether there is literally no evidence, but whether there is any upon which a judge can properly proceed to find a verdict for the party producing it.
>
> "* * *
>
> "The Federal rule is clear that when the evidence is so overwhelming on one side as to leave no doubt as to what the fact is, the trial court may and should direct a verdict or render judgment notwithstanding the verdict."

A consideration of the record in the instant case should be convincing that the Trial Judge acted in accordance with the foregoing principle of law. Assuredly, in view of the state of this record and the evaluation of the evidence which was made by the Trial Court, he would have been compelled to set aside a verdict in favor of the plaintiff in this cause, in the event such a verdict might have been rendered.

Apparently, with some misgiving, the Court submitted the cause to the jury, subject to the reservation of action on Petitioner's Motion for a Directed Verdict, which Motion was submitted at the conclusion of the evidence. (R. 738.) Subsequently, at the hearing on Petitioner's Motion for Judgment, the Trial Court frankly stated his definite convictions, to the following effect: (1) That Dr. Roosth "died believing he had hypertension and believed it long before he made application for this insurance policy"; (2) "there

are undoubtedly misrepresentations made on his part and made willfully and with knowledge that he was making them"; (3) "There is no question in my mind that those questions were material to the risk"; (4) "There is no question in my mind as a matter of law under the undisputed evidence in this case that the insurance company relied on them"; (5) "Now, if there ever was a case in which the intent to defraud was established as a matter of law, intent to deceive was established as a matter of law in my mind, this is such a case. To me, it is a most flagrant attempt to deceive the insurance company in this case. And couldn't have been done for any other purpose except with a deliberate and conscientious intent to deceive and cause them to write this insurance policy." (R. 760.) Upon the basis of these findings, the Trial Court granted Petitioner's Motion for Judgment. (Appendix A.)

Although the majority opinion is rather extensive in the discussion of the evidence in this cause, as the same relates to the various issues submitted on this appeal, we are compelled to call to the attention of the Court two very vital factual matters that apparently escaped the attention of the majority of the Court of Appeals. No comment whatever is contained in the majority opinion relative to either of such items. Inasmuch as each of such items is vital and controlling in the proper disposition of this appeal, and inasmuch as the factual situations referred to are established without any semblance of controversy, we request a careful consideration of the same.

The first of such items has its basis in the negative answer which Dr. Roosth made to Question 14(i) in the application for insurance. In answering such question, which inquired the names of any physician or practitioner he had consulted within the preceding five years, Dr. Roosth wholly failed to state that he had consulted Dr. Dera Kinsey and Dr. Reginald H. Smithwick of the Smithwick Foundation Clinic in Boston. The evidence is undisputed that Dr. Roosth consulted, and was examined by, Dr. Kinsey in November, 1951, and in June, 1953, for and because of his hypertension, in the Smithwick Foundation Clinic in Boston, and that both of such occasions were within five years prior to November 11, 1956, the date upon which such application for insurance was signed by Dr. Roosth. The evidence is also uncontroverted that during said five-year period he consulted both Dr. Kinsey and Dr. Smithwick by correspondence with them regarding his hypertensive condition and the treatment therefor.

In discussing the answer of Dr. Roosth to Question 14(i), the majority opinion makes reference only to the fact that during said five-year period Dr. Roosth had consulted Dr. Young and Dr. Ruskin, and the conclusion of the majority with respect to the answer to such question is founded on the fact that the consultation with such doctors related only to Dr. Roosth's heart condition, concerning which the insurance company was advised in the application for insurance. Manifestly, in dealing with the false answer to Question 14(i), the majority inadvertently gave no attention to the fact that Dr. Roosth had failed and refused to

mention his consultations, observations, and examinations with and by Dr. Kinsey and Dr. Smithwick, or either of them.

In Question 13 of Dr. Roosth's application for insurance herein, he was explicitly asked whether or not he had "ever been in a hospital, *clinic*, sanitorium or institution for *observation*, treatment or operation." (Italics ours.) In answering said question it appears unequivocally that Dr. Roosth failed to mention the Smithwick Foundation Clinic, or if you prefer, the clinic of the Medical Associates Group. Likewise, this factual item, which also is without contradiction, apparently escaped the attention of the majority of the Court of Appeals because no reference whatever to same is found in the majority opinion.

Here we have another instance of an express falsification or misrepresentation by Dr. Roosth of a material matter. Here again we find an instance where Dr. Roosth deliberately failed to reveal in his application for insurance that he had been examined at least on two occasions within the preceding five years by Dr. Kinsey of the Smithwick Foundation Clinic for the express purpose of observing his hypertensive condition. Two letters written by Dr. Roosth to Dr. Kinsey in November 1951 and May 1953 (Defendant's Exhibits No. 5 and No. 6) established beyond question the fact that Dr. Harold Roosth made engagements for examination by Dr. Kinsey concerning his hypertensive condition. It matters not that on each of said occasions Dr. Roosth accompanied his brother, Bennie Roosth, to Boston in order that he, too, might undergo examinations. The

fact remains that at such time he, Dr. Roosth, arranged for his personal examination and observation concerning "my hypertension."

As above discussed, in Question 13 of the application for insurance herein involved, Dr. Roosth was asked if he had "ever been in a *hospital* * * * for *observation*, treatment or operation?" Immediately following said inquiry is the following direction: "If so, give date and details. Names of Institutions. Address of Institutions. Names of Physicians or Surgeons." In answering said question Dr. Roosth made mention only of Medical Center Hospital and Mother Frances Hospital; both of which are hospitals located in his home city, Tyler, Texas. It is strikingly significant that he made no mention whatever of the fact that he had been confined in the Massachusetts Memorial Hospital for examination and observation on account of hypertension for a period of some three days from November 15 to November 18, 1950. Not only did he fail to make mention of such hospital in answer to said Question 13, but he also failed (as he was instructed to do) to give the names of physicians or surgeons who attended him while he was in such hospital. The record also shows without dispute that he was attended in said hospital by Dr. Dera Kinsey, and various other doctors, who conducted numerous tests for the purpose of determining the nature and extent of his hypertensive condition.

In the opinion of the majority of the Court of Appeals there is emphasized the fact that Petitioner, in passing upon Dr. Roosth's application for insurance, was in pos-

session of a letter written by Dr. Arthur Ruskin to Dr. Ghent Graves, Medical Director of another life insurance company, concerning the condition of Dr. Roosth in which there is a statement that "report from Massachusetts Memorial Hospital in June, 1943, noted essentially the same findings." A reading of said letter discloses unequivocally that the same has reference only to Dr. Roosth's heart condition, and the same makes no mention whatever of Dr. Roosth's hypertension. The entire purport and tenor of the Ruskin letter was to give a report concerning the then present status of Dr. Roosth relative to his heart condition. Nothing whatever is contained in said letter that would put the Petitioner, or any other reasonable person, on notice that Dr. Roosth was admitted to Massachusetts Memorial Hospital in November, 1950, "with chief complaint of hypertension," as the admission records of said hospital undeniably disclose.

We urgently insist that under the well settled rule of law the contents of the Ruskin letter were in nowise sufficient to raise a suspicion that Dr. Roosth had undergone examination and observation in Massachusetts Memorial Hospital on account of hypertension. The rule of law is well settled that a life insurance company is not estopped to rely on the false representations by the assured relative to prior medical or hospital attention as a result of information indicating otherwise, if such information within itself does not reflect the absolute falsity of the assured's representations. This rule have been recognized and reaffirmed by the Court of Appeals for the Fifth Circuit in

many decisions, among which are the following: *Jefferson Standard Life Insurance Co. v. Stevenson, 70 Fed. 2d 72,* and the more recent opinion in *New York Life Ins. Co. v. Strudel, 243 Fed. 2d 90.* This doctrine is in accord with the recognized rule in Texas as is reflected by the opinion of the Commission of Appeals adopted by the Supreme Court of Texas, in *Dossett v. Franklin Life Ins. Co., 276 S. W. 1097.*

Applying this rule to the facts in the instant case, it follows that inasmuch as the insurance company was already apprised of Dr. Roosth's heart condition, and inasmuch as the Ruskin letter purported to relate only to such condition, said letter created not the slightest suspicion in the minds of the representatives of the insurance company that Dr. Roosth also had undergone examinations and observations for hypertension. Surely it is untenable to contend that a heart condition and hypertension are one and the same ailment or disease, and that if one is afflicted with heart disease, necessarily he is also afflicted with hypertension. There is no testimony to such effect in this record, and no one contends that such is a medical fact. Indeed, it is well established that a person may have been subjected to a heart condition and have no semblance of hypertension whatever. It is the combination of the two that creates a most serious situation; and that is why the Petitioner has taken the position in this case that under the existing circumstances Dr. Roosth, who of all persons was well aware of the hazards involved, was duty bound to make truthful disclosures of his condition and experience in his application for insurance.

The majority of the Court of Appeals does not undertake to refute by factual reference to the record in this cause the evidence which we have hereinbefore discussed, and upon the basis of which the Trial Court entered judgment for the Petitioner. The most that can be gleaned from a reading of the majority opinion that can be construed to negative such conclusion are certain tenuous and unsubstantial statements which find no foundation whatever in the evidence in this cause and which constitute no answer to the position taken by the Trial Court. For instance, in undertaking to defend Dr. Roosth's failure to mention in his application for insurance the fact that he had been in the Smithwick Clinic and the Massachusetts Memorial Hospital, the majority opinion recalls that Dr. Roosth did state that he had been in two hospitals located in Tyler, Texas, but "he did not answer that he had never been in any other institution." (Opinion, p. 7.) Frankly, we cannot comprehend that a court of justice could condone such an evasion of the truth in such a manner. Here Dr. Roosth was called upon to name *all* of the hospitals and clinics in which he had been treated or observed, and the fact that he mentioned two hospitals in his home town, but failed to mention a hospital and a clinic in Boston, Massachusetts, constituted a mis-statement of the facts, nevertheless. A half truth is still an untruth.

As a further excuse for the failure of Dr. Roosth to mention in his application for insurance that he had been in Massachusetts Memorial Hospital, the majority opinion

recites that "The evidence shows that insured was not admitted to said institution as a patient or for treatment." (Opinion, p. 7.) Although the undisputed record shows that Dr. Roosth remained in Massachusetts Memorial Hospital for a period of three days from November 15 to 18, 1950; the statement that he was not admitted as a patient is beside the point. Question 13 in the application for insurance signed by Dr. Roosth inquires whether or not the applicant "ever has been in a hospital, * * * for observation, treatment or operation." (Defendant's Exhibit No. 3.) The salient fact is that Dr. Roosth himself underwent a three-day confinement in Massachusetts Memorial Hospital for observation in connection with "his chief complaint of hypertension," as reflected by the case history taken by Dr. Horwitz upon Dr. Roosth's admission to the hospital. (Defendant's Exhibit No. 17.)

Finally, in a rather desperate gesture to justify its position that in spite of the uncontroverted evidence, this cause should have been submitted to the jury, the majority opinion concludes with the argument that inasmuch as Dr. Roosth "was a prominent and outstanding citizen in his community," and that "* * * he was a man of means," such facts negatived the fraudulent acts that he prepetrated upon the Petitioner. Apparently epitomizing the basic reason why it was concluded by the majority of the Court of Appeals in the case at bar that a jury should be permitted to render a verdict in this case, is the following very re-

markable statement which is found in the concluding paragraph in the opinion of the majority:

> "It is a rare case which would justify a finding that, as a matter of law, a man of character has stooped to the cheap fraud relied upon here. We think that it was error for the Judge so to decide. The case, in all of its aspects, should be decided by a jury." (Opinion, p. 19.)

Thus, we are inevitably driven to the opinion that irrespective of applicable legal principles and rules of procedure, the majority of the Court of Appeals has decided that a man accused of fraudulent acts may be acquitted of the consequences of same by proof of his wealth and prominence. The natural inference to be drawn from such a statement as is found in the majority opinion is that as a matter of law when a man becomes a millionaire, and a prominent citizen, he then becomes beyond reproach. Since when, may we ask, has it come to be recognized as a legal principle that a man's integrity is measured by his wealth and social prominence? We respectfully submit to this Honorable Supreme Court that it is unthinkable that such reasoning as the majority of the Court of Appeals has employed in this instance should be permitted to remain unchallenged.

The only plausible explanation that can be given for the conclusion reached by the majority herein is that the majority concluded that under no circumstance or condition should an action of this nature be withdrawn from consideration of the jury. Such conclusion, of course, is out of harmony with long-established and well-recognized legal procedures.

Majority Decision Places Undue Burden on Life Insurance Industry

The insured, by consenting to undertake a risk, does so under an implied condition that it shall be equally informed with the insured as to all material circumstanees so that it may judge the nature and etxent of the risk for itself. *Appleman on Insurance Law and Practice, Vol. 12, Section 7271.* Fair dealing between the insured and the insurer was prescribed as the requisite rule of conduct in an early decision of the Supreme Court in which the opinion was written by the eminent Chief Justice Marshall in *Columbian Ins. Co. v. Lawrence, 27 U. S. 25; 2 Pet. 25; 7 L. Ed. 335.* In said opinion Chief Justice Marshall stated:

> "Fair dealing requires that he (the insured) should state everything which might influence, and probably would influence, the mind of the underwriter in forming or declining the contract."

The same rule was reiterated in a more recent opinion of the Supreme Court written by Justice Stone in *Stipcich v. Metropolitan Life Ins. Co., 277 U. S. 311; 72 L. Ed. 895,* in the following language:

> "Insurance policies are unconditionally contracts *uberrimae fidei* and a failure by the insured to disclose conditions affecting the risk, of which he is aware, makes the contract voidable at the insurer's option. • • •.
>
> "For, even the most unsophisticated person must know that in answering the questionnaire and submitting it to the insurer he is furnishing the data on the basis of which the company will decide whether, by issuing a policy, it wishes to insure him."

There can be no question that a revelation in the application that Dr. Roosth had consulted the doctors of the Smithwick Foundation Clinic in Boston would have been most significant. The testimony of Appellee's Chief Medical Director, Dr. Scoins, that the Smithwick Foundation Clinic bears an outstanding reputation for treatment and surgical operations for hypertension, is unchallenged. Dr. Scoins stated, therefore, that if he had known that Dr. Roosth had been examined by the doctors of the Smithwick Foundation, or that he had been to the Smithwick Clinic, such information would have been most significant in passing upon Dr. Roosth's application, and that most certainly the Petitioner would have made inquiry of the Smithwick Clinic for a clinical report and findings concerning Dr. Roosth before approving his application for insurance. (R., pp. 502, 503, 506.)

Grant, for the sake of argument only, that Dr. Roosth was not afflicted with hypertension as a disease, or even with so-called essential hypertension. Grant further, for the sake of argument, that Dr. Roosth was subject only to intermittent periods of high blood pressure. Nevertheless, the facts remain undisputed that Dr. Roosth was examined by doctors in Boston with "chief complaint of hypertension," and that he had three of such examinations over a period of four years by doctors of the Smithwick Foundation Clinic, and that he continued to consult with such doctors concerning "his hypertension" until after he made the application for insurance involved herein. That these examinations and consultations took place, the Petitioner insurance company

was entitled to know in answer to Questions 14(h) and 14(i) in its application, in order that the Petitioner might be able properly to consider and evaluate Dr. Roosth's application for insurance. Irrespective of whether or not Dr. Roosth actually was afflicted with hypertension, or merely an occasional period of high blood pressure, the insurance company was entitled to know the facts concerning consultations with doctors, for the purpose of ascertaining whether or not he was afflicted with hypertension, so that the insurance company could then reach a decision whether or not under all the circumstances it desired to approve the application.

Moreover, the evidence leaves no doubt that the Petitioner would not have approved Dr. Roosth's application for insurance if it had been advised that he was afflicted with hypertension. The reason, as stated by Dr. Scoins, Chief Medical Director of the insurance company, is that hypertension materially decreases the life expectancy of one who has had a heart attack. (R., pp. 498-499; 512-513.) Appellee's Manual of Instructions to Medical Examiners, relating to disregarding history of high blood pressure, referred to on page 8 of the majority opinion, palpably has no significance here. Such instructions relate to high blood pressure alone, and not to high blood pressure superimposed upon a history of a heart attack. It is the combination of the two elements, heart condition and hypertension, that gives rise to uninsurability.

To be sure, as is stated on pages 14 and 15 of the majority opinion, it will be conceded that Dr. Roosth as a coro-

nary patient remained heart conscious. By the same token, being well informed of the additional hazard of the hypertension with which he was burdened, there existed all the more reason for Dr. Roosth to be apprehensive of his condition and his future. Therefore; considering his answers to the questions in the application for insurance, from the viewpoint of what he had in mind when he gave them, it is inevitable that he knew that a revelation of his hypertensive condition, when considered in connection with his heart history, would defeat his purpose to obtain life insurance.

There is at issue in this Petition for Writ of Certiorari the maintenance of the basic principle that an insurance company is entitled to rely upon the statements and representations in applications for life insurance, especially in cases where the application is made by one who is exceptionally qualified to possess full knowledge of the nature and truthfulness of such statements and where the falsity thereof is unequivocally established by his own unimpeached and documented declarations. The life insurance industry has become one of the most important businesses in our economy, as well as in our social structure. Indeed, the continuation of the welfare of this nation, to a significant degree, depends upon a proper concept of the relations between insurer and insured.

If the time has arrived, as is indicated by the majority opinion of the Court of Appeals in this cause, when a life insurance company can no longer expect to be protected in our tribunals against deliberate falsifications in applications for insurance, then a complete revision of the life

insurance processes will become inevitable. If trial courts are denied the authority to direct verdicts in favor of life insurance companies in suits upon policies that have been procured through fraudulent misrepresentations by the insured, then applications for insurance will become but meaningless and useless words upon mere scraps of paper. The ultimate consequences of such a drastic revision in insurance procedures will be most costly, not only to life insurance companies, but also to the millions of people who may desire to procure life insurance. Undoubtedly the additional cost of procuring life insurance under such conditions will be monumental, and necessarily the burden of such additional cost must be borne by the public who purchases the insurance.

Majority Decision in Conflict with Other Decisions

As is indicated in the dissenting opinion herein of Chief Judge Hutcheson of the Court of Appeals for the Fifth Circuit, the decision of the majority is clearly out of harmony with the decision of the Supreme Court of the United States in *Pence v. United States, 316 U. S. 332, 81 L. Ed. 1510.* Moreover, as is further indicated in Judge Hutcheson's dissenting opinion, the decision of the majority is contrary to other decisions of the same Court of Appeals for the Fifth Circuit in *United States v. Stratton, 232 Fed. 2d 800*, and in *McDaniel v. United States, 196 Fed. 2d 29*, and in *Rhodes v. Metropolitan Life Ins. Co., 172 Fed. 2d 183.*

In the *Pence* case, the wife of a deceased doctor who had been in the service of the United States Government,

sought to recover the proceeds of a government life insurance policy. The Government defended on the ground that said policy, which once had lapsed, had been reinstated on the strength of fraudulent representations made by the insured that he had not been treated for certain diseases and had not consulted physicians in regard to his health. A directed verdict for the Government was sustained by the Supreme Court on the ground of such representations, in view of the introduction of certain documentary evidence signed by the insured which revealed the falsity of the statements he had made in his application for reinstatement, even though there was evidence to the effect that the insured was in apparent good health at the time of the reinstatement and further, that his wife testified that she had no knowledge of the facts which established the misrepresentations. The fact that the insured himself was a doctor, and thus, was well acquainted with the importance and effect of the statements contained in the application for reinstatement, was significant in the conclusion of the Court that such statements were made with intent to deceive, as a matter of law. We quote from the language of Justice Jackson in the Court's opinion, as follows:

> "Pence's representations in the application were not evidence of their own veracity. His later contrary statements were repeated, and usually under oath; they are in no way improbable, and are the statements of one who, being himself a doctor, spoke with knowledge of the subject and bearing of his statements. His admissions left no room for conjecture as to the falsity of the previous statements in the application, and of his knowledge of such falsity. * * *."

Two rather recent decisions of the Court of Appeals for the Fifth Circuit have applied and expressly followed the principle of law announced by the Supreme Court in the *Pence* case. Reference is made to *McDaniel v. United States*, and *United States v. Stratton*, supra.

In both of said cases the Government defended suits by beneficiaries to recover the proceeds of national life insurance policies on the ground that in the applications for reinstatement of such policies the insured made misrepresentations of fact concerning his good health at that time and concealed his consultation with doctors since the lapse of the policy. Conceding that such answers of the insured did not fully and correctly state the true facts, the claimants sought to recover on the ground that such misrepresentations were not wilfully and fraudulently made with intent to deceive. In each case the Court of Appeals for the Fifth Circuit denied recovery on the policy. Sustaining the position of the Government in the *McDaniel* case, the following language is found in the opinion of Judge Hutcheson:

> "In agreement throughout with the positions taken by appellee, we think it entirely clear that no amount of casuistry short of that which would make black seem white, the false true, can explain away or justify the false answers the insured deliberately gave twice in almost a few months."

In the *Stratton* case, the cause was tried to a jury and defendant's motion for a directed verdict having been denied, there was a verdict and judgment for the plaintiff. On appeal the United States insisted that the evidence

established, as a matter of law, that the answers of the insured in his application for reinstatement of the policy, that (1) he was then in as good health as on the date the defaulted premiums became due, and (2) that he had not been ill or consulted a physician since such default, were known by him to be untrue and were fraudulently made to deceive. The evidence showed that the insured was an intelligent manager and salesman for a wholesale grocery firm, and that on the day before he tendered the overdue premiums he had a loss of consciousness, which required his hospitalization. No definite diagnosis of the cause of the unconsciousness was made, but the insured died about one month thereafter from a brain tumor, which was disclosed by an autopsy. Following the holding in the *Pence* case and the *McDaniel* case, the Court of Appeals reversed the judgment of the trial court and rendered same in favor of the appellant.

In the *Stratton* case, as well as in the *McDaniel* case, the claimants relied upon another decision also rendered by the Court of Appeals for the Fifth Circuit, *Cardwell v. United States, 196 Fed. 2d 382*, which is also cited by Appellant in her brief herein. In this case it was held that the issue of fraudulent intent was one of fact that should have been submitted to the jury for determination. Distinguishing the *Cardwell* case, Judge Hutcheson called attention in both the *McDaniel* case and the *Stratton* case to the fact that in the *Cardwell* case the insured was a carpenter who "not only did not know that he had a serious disease, but on the contrary had been advised by his physician that his trouble

was imaginary and that there was nothing physically wrong with him"; whereas, in the *McDaniel* case the decedent was a lawyer and a college graduate, and in the *Stratton* case the decedent was a responsible business man, and each of them knew that he was seriously afflicted with a physical disease or disability, albeit each one may not have known the exact nature thereof. In consequence thereof, the conclusion of the Court in the *Stratton* case and in the *McDaniel* case is epitomized by the following language of Judge Hutcheson in the opinion in the *Stratton* case:

> "We think the facts in this case, including what was physically happening to the deceased at the very time that he was seeking by statements, which he knew to be false, to obtain a reinstatement of his policy, are of such force as to compel the conclusion that no honest person could reasonably have given the false answers he gave without intending to defraud, and that no jury could have reasonably found that he did not so intend."

It is urgently submitted that the undisputed facts in the case at bar bring it within the purview of the decisions in the *McDaniel* case and the *Stratton* case, and likewise distinguish it from the holding in the *Cardwell* case. Here, as in the *McDaniel* case and in the *Stratton* case, the insured was a man of intelligence, splendid education, excellent training, and a specialist of the specific field of medicine in which the disease with which he was afflicted was concerned. Consequently, he, of all persons in the world, was in the position to know that he was afflicted with hypertension, that it was an incurable disease, and that the prospect of his life expectancy was very limited, in view of his hypertension superimposed upon his heart condition.

He repeatedly admitted, in his own words, over a period of seven or eight years prior to his death, that he was afflicted with hypertension, and to his dying day he never denied it. Therefore, we earnestly hold to the opinion, as did the trial court, that Dr. Roosth believed and knew, when he applied for the insurance involved in this litigation, that he was afflicted with hypertension, and he concealed the fact for the purpose of deceiving the Petitioner and inducing it to write the policy of insurance herein sued upon.

The issues required to be proven in order to establish the defense of false representations in applications for life insurance policies, in cases in the Federal Court dealing with National Service Life Insurance, are the same as those which are prescribed by the Texas courts in dealing with ordinary life insurance cases. In fact, in the *McDaniel* case, there are laid down the five identical elements which are prescribed by the Supreme Court of Texas to be proven in order to establish the defense of misrepresentation in applications for insurance policies, namely: (1) A false representation; (2) in reference to a material fact; (3) made with knowledge of its falsity; (4) and with intent to deceive; (5) with action taken in reliance upon the representation.

The leading case rendered by the Supreme Court of Texas which announces the foregoing requisites is *Clark v. National Life Ins. Co.*, 145 Tex. 575, 200 S. W. 2d 820. However, in no event can the conclusion be drawn from the opinion in that case that each, or all, of said elements are necessarily questions of fact under Texas law. Indeed, in

connection with the discussion of these elements, the opinion in the *Clark* case contains the following express pronouncement:

> "Uncontroverted questions of fact need not be and should not be submitted to the jury for its determination; but they are proper subjects for peremptory instruction by the court."

In *Rhodes v. Metropolitan Life Insurance Company*, 172 *Fed. 2d 183*, the Court of Appeals for the Fifth Circuit had under consideration false reresentations in an application for a life policy, that the insured had no disease of the kidneys, that he had never had diabetes, and had not consulted a physician within the previous five years, as grounds for denial of liability under the policy. On the question of the materiality of such false representations this Court, in an opinion by Judge Lee, made the following comments, which we submit are very pertinent to the case at hand:

> "* * * Assuming that the insured was not guilty of fraud but was acting in good faith, the decisive question is whether the representations were material to the risk. We think, as a matter of law, they were. It cannot reasonably be supposed that the insurance company would have issued the policy if it had been informed of Dr. Hirsch's examinations, the tests he made, his diagnosis, and the treatment he prescribed and Dampf followed. Where all the testimony relating to a question of fact excludes every reasonable inference but one, the issue becomes one of law for determination by the Court. Lee v. All States Life Ins. Co., 49 Ca. App. 718, 176 S. W. 811, 813. The insured was shown to be a man of affairs, with fairly large business interests, and must have known that the purpose behind questions concerning his health and habits was

to enable the defendant to determine whether it would issue the policy. The statement of the court in First Trust Co. of St. Paul v. Kansas City Life Ins. Co., 8 Cir., 79 F. 2d 48, at page 54, is apposite: "* * * He could not have regarded a diabetic ailment as so trivial that an insurer would not want to know about it. The only possible rational explanation of his conduct is that he willfully made the false statements for the purpose of concealing the facts and of deceiving the insurer so that he might procure a policy which, if this truth were known, might be refused. In this situation of fact the only question is one of law and that is easy of solution. * * *."

Because of its particular similarity to the facts in the instant case, and its pronouncement of the relative law on the issue of materiality of false representations in an application for insurance, we make special reference to the decision of the Court of Appeals for the Fourth Circuit in *Atlantic Life Insurance Company v. Hoefer, 66 Fed. 2d 464*. The facts in this case disclose that the insured stated in his application that he was then in good health, that he had had a tonsillectomy, but that otherwise he had not consulted or been treated by a physician during the past ten years, and that he had had no other ailment or illness. The truth was that approximately three years previously he had had his blood pressure examined and same was found to be above normal. Thereafter, for a period of three years, his blood pressure was taken at regular intervals, and same being high and being accompanied by headaches and neuralgia, upon the advice of his physician, he was placed on a diet and submitted to the removal of his tonsils and also infected teeth. Thereafter his blood pressure became reduced for a time, but subsequently it fluctuated

between normal and abnormal ranges during a period of three years. After three years he died of a cerebral hemorrhage, shortly after the policy of insurance in question was written. We quote the conclusions of the Court relative to the materiality of the misrepresentations involved in the case cited as follows:

> "If this medical history of the insured had a material bearing upon the risk involved, the failure to communicate it to the insurance company prevented recovery in this case; for it is not a sufficient excuse that the insured believed that he had been cured when his blood pressure came down after the removal of his tonsils and some of his teeth. It was for the company and not for him to decide upon what terms, if at all, it was willing to insure his life. The medical testimony in the case shows quite conclusively that a blood pressure of 160 is abnormally high for a person of the age of the insured, and the maintenance of such a pressure for a substantial period of time is likely to be followed by a permanent hardening of the blood vessels, a condition of much significance in estimating the chances of longevity. Medical directors of several life insurance companies testified without contradiction that a well-regulated insurance company would have either refused the risk involved or have demanded further tests, or have required a higher premium, if the true facts had been communicated to it, and that this action would have been in accordance with underwriting rules and practices commonly employed by life insurance companies.
>
> "It follows that the facts omitted by the insured from his answers to questions propounded to him in the application had a material bearing upon his general health, and upon the risk which the company was requested to undertake; and the great importance of these inquiries is all the more clearly seen from the death of the insured from cerebral hemorrhage shortly after the policy was issued. * * *."

The element of the materiality of misrepresentations is not dependent upon a showing that the facts misrepresented had a direct relation to the cause of death. The recognized principle of law on this issue is found in the pronouncement of Judge Lee in *Rhodes v. Metropolitan Life Ins. Co.*, supra, as follows:

> "The argument that the misrepresentation was immaterial because the insured died from coronary thrombosis and not from diabetes, we think begs the question. The real issue has to do with the circumstances under which the defendant assumed the risk, whether it would have assumed the risk it did assume had the truth with respect to Dampf's health been made known to it. The cause of insured's death is not important, because the insurer would have had the right to cancel the policy if insured were still living."

There are numerous other decisions by the United States Courts of Appeals which might be cited in further support of the foregoing proposition. In the interest of time and space we shall pretermit any such further citations save and except one. We refer to the decision of the Court of Appeals for the Fourth Circuit in *McSweeney v. Prudential Insurance Company, 128 Fed. 2d 660 (Certiorari denied)*. This case arose in South Carolina, where, as in Texas, the law requires not only that the falsity of representations in the application for insurance, but also the intent to defraud, must be established in order to defeat recovery. The facts in the case cited are strikingly similar to those in the case at bar. Here the insured made false answers relative to his blood pressure and to previous consultations with physicians, in his application for insurance. In overruling the contention of the plaintiff that the decisions of

the South Carolina courts, to the effect that the issue of fraudulent intent was for the jury, the opinion in this case, which was written by that eminent jurist, Chief Justice John J. Parker, contains the following comment:

"* * * While the cases relied on are authority for the position that a fraudulent intent in addition to the false representations there shown is necessary to establish fraud, they are not authority for the position that fraudulent intent is not to be inferred from the making of false representations which are false within the knowledge of the person making them and are material and made to be acted on; and they do not militate against the holding of the Johnson case to the effect that fraudulent intent must be inferred from such representations when no other conclusion can reasonably be drawn from them. * * *.

"Applicant is shown by the evidence to have been a man of intelligence and the publisher of three rural newspapers. He must have known the significance of the numbness in his left side and the thickness of tongue which accompanied it. He consulted a specialist, and was told that he had abnormally high blood pressure, and took the matter so seriously that he took off weight too rapidly as a result of following the diet prescribed for him. Nevertheless he entirely failed to disclose these serious matters in response to the questions in the application making specific inquiry with regard to them, although he did mention treatment by a different doctor for a minor ailment. He was uninsurable and must have known that he was uninsurable; and if he had truly disclosed the facts as to which specific inquiry was made, he would never have obtained the policy. He obtained it by false answers, known to him to be false, which concealed his true condition. As said in the Johnson case, 'the undisputed facts can reasonably give rise to only one inference, namely that the policy was procured by fraud'."

The legal doctrine announced by the foregoing authorities is well recognized and followed by the courts of Texas. The statement is substantiated by the recent decision in *John Hancock Mutual Life Ins. Co. v. Esparza, 286 S. W. 2d 695*, decided by the Court of Civil Appeals at San Antonio in 1956 (Writ of Error refused, N. R. E.). This was an action brought by the insurance company to cancel a reinstated life policy after the death of the insured on the ground that statements made by the insured in the application for reinstatement, that insured was then in sound health and had not consulted or been treated by a physician, were false. The jury found that the insured did not intend by his false statements to induce the reinstatement of the policy, and judgment was rendered for the claimant. However, the appellate court held that inasmuch as such false statements were not ignorantly or innocently made, but that the insured then knew that he was suffering from a malady and was receiving medical treatments, the same negatives the jury finding that he did not intend to deceive. Thereupon the Court of Civil Appeals concluded as follows:

> "The motion for judgment non obstante veredicto should have been granted. We conclude, in any event, the finding that there was no intent to deceive is against the overwhelming preponderance of the evidence. The judgment is reversed and rendered canceling the policy."

The authorities hereinbefore cited clearly demonstrate that the opinion of the majority of the Court of Appeals for the Fifth Circuit in the instant case is completely out of harmony with the holdings in many decisions which are

considered authoritative. Not only is the majority opinion of the Court of Appeals contrary to the rulings, in cases with similar factual situations, of other United States Courts of Appeals, but the same, likewise, is contrary to the pronouncement of the law and decisions of the Supreme Court itself.

Equally as strange is the very evident fact that the decision of the majority is in strict disagreement with other decisions recently rendered by the same Court of Appeals. This situation is expressly adverted to in the dissenting opinion of Judge Hutcheson. Nevertheless, the majority opinion made no reference whatever to the *Stratton* case, the *McDaniel* case, or to the *Rhodes* case. Therefore, it cannot be considered that it was the purport of the author of the majority opinion, nor of his concurring associate, to overrule either the *Stratton* case or the *McDaniel* case or the *Rhodes* case. In consequence of the inconsistencies thus created, it follows that both Bench and Bar, as well as litigants—present and prospective—are cast into a state of utter inconclusion and uncertainty with reference to the rule of law here under discussion. To the end that this chaotic condition may be relieved, we respectfully suggest that this Honorable Supreme Court should grant the Petition for Writ of Certiorari herein sought.

CONCLUSION

Sincerely believing that a reversal of the decision of the majority of the Court of Appeals for the Fifth Circuit in

the case at bar, for the reasons hereinbefore assigned, is in the public interest and is of supreme importance to the jurisprudence of this nation, as well as to the important insurance industry, we earnestly urge upon this Honorable Supreme Court that this Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit be granted and this cause be brought on for review by this Honorable Supreme Court.

Respectfully submitted,

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APPENDIX A

The Court:

I might first state this, gentlemen, that I see no difference in the Texas Rule on this matter as laid down by the Supreme Court in the *Clark* case which is the bellwether case on this question of fraudulent misrepresentations and the rule laid down by the Supreme Court of the United States in the *Pence* case. The elements of fraudulent misrepresentations are identically the same. Now, the right of trial by jury in the Federal Court in those cases in which they are entitled to trial by jury are identical to those cases of trial by jury in Texas. And, in the citations on whether or not a question of fact is raised, the same rule applies.

Now the Judges sitting in the Texas Courts might take a different view of it than the Judges sitting in the Federal Court. Now, on this point as in the *Pence* case, the three judges on the Supreme Court thought a question of fact had been raised.

In this *Stratton* case Judge Cameron thought a question of intent was raised. And, as I said a moment ago, after we tried this case and after hearing all of the evidence and after having done some briefing at the time of trial and I was convinced after the close of evidence that the Defendant was entitled to an Instructed Verdict save and except for the question of intent to deceive which I wasn't at all sure about. And that is why I sent this case to the Jury.

Now, there is no question even if we will say the question of fact might be raised as to whether the doctor had hypertension; there is not the slightest doubt in my mind that under any reasonable interpretation of the evidence in this case, Dr. Roosth died believing that he had hyptertension and believed it long before he made application for this insurance policy. There are undoubtedly misrepresentations made on his part and made willfully and with knowledge that he was making them. The first statement that he made about his not being in any hospital except the two hospitals that he listed. The other is that he said that no doctor had found his blood pressure to be above normal. He believed that statement to be false when he made it. His own handwriting in this record conclusively shows that. And then, of course, the fact that he stated that he hadn't consulted any other doctor within five years is bound to have been false and he knew that it was false. There is no question in my mind that those questions were material to the risk. There is no question in my mind as a matter of law under the undisputed evidence in this case that the insurance company relied on them.

Now, then, we come down to the real question as to whether or not he made those misrepresentations with the willful knowledge to misrepresent it to the insurance company. Now, we have to go back and take into consideration Dr. Roosth's mind and heart and from the reasonable inferences that could be drawn from this case. Now, there again his belief in the matter as to what he was suffering with becomes of great importance. Now, as I said a while

ago, Dr. Roosth believed at all times up until the time of his death that he was suffering from hypertension. He was a well educated man according to the evidence in this case. He had special training in the very field in which this condition falls. And there is no question in my mind that Dr. Roosth not only knew he had hypertension, but from the evidence in this case, he was considerably alarmed about the matter every time he wrote the doctors, except that last post card, he so indicated and particularly the letters he wrote. Now, if there ever was a case in which the intent to defraud was established as a matter of law, intent to deceive was established as a matter of law in my mind, this is such a case. To me, it is a most flagrant attempt to deceive the insurance company in this case. And couldn't have been done for any other purpose except with a deliberate and conscientious intent to deceive and cause them to write this insurance policy.

Therefore, the Motion of the Defendant for the entry of Judgment in accordance with the Motion for an Instructed Verdict will be granted and the Defendant shall prepare and enter an appropriate form of order after submitting it to the Plaintiff's counsel for approval.

APPENDIX B

In the

United States Court of Appeals

FOR THE FIFTH CIRCUIT

No. 17426

ROSA LEE ROOSTH,

Appellant,

versus

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY,

Appellee.

Appeal from the United States District Court for the Eastern District of Texas.

(July 30, 1959)

Before HUTCHESON, Chief Judge, and CAMERON and BROWN, Circuit Judges.

CAMERON, Circuit Judge: December 24, 1956, Dr. Harold Roosth (insured), a practicing physician in Tyler, Texas, applied to The Lincoln National Life Insurance Company (insurer) for $50,000 life insurance with appellant Rosa Lee Roosth, his wife, as beneficiary. The policy was issued on the same date after the usual

medical examination and was delivered to insured soon thereafter. After paying two monthly premiums the insured died February 7, 1957, the death certificate showing as the cause of death "Sub-arachnoid hemorrhage due to ruptured aneurism." The insurer declined the beneficiary's claim under the policy on the ground that insured had made false statements and misrepresentations in his written application for the policy knowing they were false and making them with intent to deceive the insurer, claiming that said false statements and misrepresentations were material to the risk assumed by insurer and were relied upon by it and it was induced thereby to issue the policy; and that the insured was not in good health when the policy was issued and delivered to him.

This civil action brought by the beneficiary was tried before court and jury and, after prolonged deliberation, the jury reported its inability to agree upon a verdict and was discharged. Thereupon the court, after hearing argument and considering briefs, entered judgment granting insurer's motion for directed verdict based upon the averment that each of the defenses relied upon by it had been established by "the uncontradicted and or great preponderance of the evidence." The question presented by this appeal is whether the defenses relied upon were established by evidence of such character that the court below was justified in deciding that no jury issues were presented, and that the defenses should be sustained as a matter of law; and that the insurer had not waived, or was not estopped to prevail on, its motion for directed verdict by reason of notice of facts omitted from the appli-

cation it acquired prior to the issuance of the policy. A careful reading of the record and briefs convinces us that, under Texas law, the evidence required that the issues be decided by the jury and that it was error to decide them as a matter of law.

The trial below was prolonged and the record is made up largely of the testimony of nine doctors who gave their opinions based, to a large degree, upon hypothetical questions. Without doubt, there is support in the record for a jury finding in favor of the insurance company, but that is not the question which is before us. Ours is the duty to search the record to see if it contains credible evidence from which the jury would have been warranted in finding for the appellant. The opinion, therefore, will be confined largely to pointing out the evidence favorable to the appellant and the law of Texas under which, in our opinion, a case for the jury was made out.

A few fundamental facts should be kept in mind as the details are considered. The first is that Lincoln made a specialty of substandard risks and its premium charges were based accordingly. The annual premium normally applying to the policy issued to insured was $1094.00 per year, while the charge made for the policy issued to him was $1,922.00 per year, an uprating of 74.7 per cent. The insurer knew that the doctor had had a mycocardial infarction, commonly known as a coronary thrombosis, in 1948, and that the American General Insurance Company had, five years thereafter issued him a rated-up

policy.[1] Insured knew that he was a permanent cardiovascular cripple and, despite his comparative youth, had cut down on his activities to protect himself from future attacks. He was inevitably heart conscious and was probably never free from a measure of anxiety and foreboding. The insurer also knew this. That occurrence was the basic ingredient of the contract between the two and the congeries of considerations attending it, the causes, the concomitants and the consequences were logally taken into account in the execution of the contract, and every act by the parties in connection with it should be interpreted in the light of this fundamental fact.

The idea of insurance originated, not with the insured, but with the insurer. The insured felt sufficiently encouraged concerning his recovery and general physical condition to go in with his brother, also a doctor, and construct a clinic, which was occupied in the year 1956. Insured was exploring the covering of the mortgage on the clinic by what was referred to as "mortgage insurance." But Lincoln's agent learned of the situation and importuned insured to purchase life insurance instead, sending in to Lincoln on Nov. 1st an inquiry whether it would be interested in writing it. The amount desired by insured was $26,000, and the application first signed by him November 10, 1956 was for a policy in that amount. The agent inserted in that application the request that an additional policy in the amount of $24,000 be issued. The physical

[1] The record reveals that Lincoln was reinsurer of some of American General's risks that they swapped information and cooperated in determining whether applications for insurance would be accepted.

examination by the company examiner, Dr. C. B. Young, was based upon the November 10th application. Insurer's agent, however, testified that the policy was issued on the application dated December 24th, but upon the medical examination made November 11th.

Lincoln pled affirmatively that insured willfully made false answers to specific questions asked him by the medical examiner, as set out in the footnote.[1] It is first complained that insured misrepresented the cause of the death of his mother. Since insured was thirteen years of age at the time of her death, it is clear that he knew nothing of the cause and the answer on his application is bound to have been the repetition of what he had heard. His brother explained that family history revealed—as the brother expressed it, they were taught—"That she died from a kidney condition resulting from childbirth." That is essentially what the death certificate showed.

The Company introduced evidence that, in 1950, insured told someone making a physical examination of him that

[1] "9. Mother Age at Death 40 Cause of Death—Childbirth."

"11. Have you now any disease or disorder? If yes give full particulars." Answer: "No."

"13. Have you ever been in a hospital, clinic, sanitarium or institution for observation, treatment or operation? If so, give date and details . . ."

Answer: "Medical Center Hosp. Nov. 1955.
Mother Frances [Hospital]
Hemmorrhoidectomy 1950
Porter Bailes, Jr. [Surgeon]

"14. Have you ever had any of the following diseases or symptoms? a. Apoplexy, Paralysis, Epilepsy, Loss of Consciousness, Dizziness, Nervous Breakdown, Headaches." Answer: "No."

"g. Has any physician in past five years found your blood pressure above normal?" Answer: "No."

"h. Have you ever had X-ray, electrocardiogram or blood studies? If so, give full particulars." Answer: "No."

"i. Have you consulted any physicians or practitioners the past five years for any other causes?" Answer: "No."

his "mother died at 39 of cerebral vascular accident." His recollection then was no better apparently than it was when he applied for his insurance. At the time of the application he gave his mother's age at death at 40. At the time of the asserted admission against interest in 1950 he gave her age as 39. The death certificate showed that she was 45. If the answer should be considered of any consequence, the jury had a right to believe that the insured gave the best information available to him. Especially is this true when, on the same application, he showed that his father died at the early age of 62 of coronary thrombosis, and the evidence is replete with the showing that his brother was the victim of extreme hypertension for which a serious operation was performed in 1950.

Skipping over to question No. 14 (a) concerning seven listed afflictions, including dizziness and headaches, there is abundant evidence that insured had never suffered from dizziness or headaches of any consequence. The evidence to the contrary can serve only to make this a jury question.

The remaining questions with respect to which the insurer claims false and fraudulent misrepresentations may be grouped, because the same evidence relates to all of them. The insured answered, in response to question 13, Note 2, *supra*, that he had been in two hospitals, one in 1955 and one in 1950. He did not answer that he had never been in any other such institution. Moreover, the question related only to "observation, treatment or operation." The Company's chief point about this answer is

that insured had, in November, 1950, undergone a complete physical examination by the doctors of the Smithwick Clinic at Massachusetts Memorial Hospital in Boston. In that connection, the evidence showed that insured was not admitted to said institution as a patient or for treatment. His check-up was a mere incident to his trip to Boston to take his brother who was seriously ill of hypertension, and the insured merely submitted to the general examination during the time he was detained there waiting for his brother to develop enough strength for the serious operation.

The most serious admission against interest relied upon by appellee was contained in the case history which was taken from insured on this occasion. The intern taking the case history made this note: "About four years ago after discharge from the army with no reservation it was noted that he had a BP of 160 100-110. He was completely asymptomatic until the middle of September, 1948, when he had two weeks of 'indigestion' followed by a full blown posterior myocardial infarction. He recovered and slowly has increased his activity to 5-6 hours of work (internist) a day. Since the coronary he has ceased smoking and has been taking 150-200 mg of dicumarol every other day, following it with a prothrombintime once a week."

The physical examination then conducted showed an average lying blood pressure of 186 129, but it fell markedly after rest and, under sedation, reduced to 110 70; the testimony disclosed also that the eyes were "clear," that the heart was not enlarged, and that the electrocardiogram was normal.

In connection with this evidence it should be considered that Lincoln, in its manual of instructions to medical examiners, advised that blood pressure history beyond five years should usually be disregarded; and, as to more recent history, the following instruction was given: "History three to five years ago—if highest systolic in history 3 to 5 years ago was less than 170 and highest diastolic less than 106, disregard . . ."

Several things connected with the 1950 checkup are worthy of note. One is that the history given by the insured to the Boston doctors began with his discharge from military service and included the period of his coronary thrombosis and ended more than six years before the application for insurance; and the moderately elevated blood pressure was manifestly connected in insured's mind with the thrombosis experience.

The examination in 1950 by the doctors of Smithwick Foundation showed insured's blood pressure to be high, but the other tests for hypertension were negative. At that time, insured was scarcely two years away from the grueling experience of the "full blown myocardial infarction" and he was in Boston with full responsibility for a very sick brother, charged with the duty of deciding whether a serious operation should be performed. No doctor who testified held the idea that such an experience would not of itself produce an unusually high blood pressure resulting from nervousness and worry. That the elevation of pressure then discovered was connected with emotional stress is buttressed by the fact that, when the

stress was eliminated by sedation, his pressure dropped to the subnormal figures of 110 70.

Under like circumstances as those detailed with respect to the first visit, insured was examined at the same institution Nov. 25, 1951,[3] and again in June, 1953. Both times, the blood pressure levels were well under those Lincoln had established as such a safe standard as to be disregarded.

In connection with that evidence, it should be noted that the insured's doctor brother testified that he had, during the years, taken the insured's blood pressure on numerous occasions and had never found it high; and Dr. Ruskin testified substantially the same thing. Except, therefore, for the one time in 1950 when insured was under such tremendous nervous strain, there was no showing that insured's blood pressure ever exceeded that which Lincoln instructed its examiners to disregard. In addition to this, insured's blood pressure was apparently satisfactory to American General when it issued its policy in 1954, and was 130 85, as noted by the insurer's examiner on the report of examination of insured upon which this policy was issued. Moreover, on the preliminary report made Nov. 1, 1956, as a feeler to determine whether Lincoln would be interested in issuing the policy, it was noted that a current or recent 12-lead electrocardiogram would be required by it.

During all the years of their association in the practice of medicine insured had never mentioned to his doctor

[3] The average blood pressure found in 1951 was, lying, systolic 138, diastolic 86, and standing, systolic 140 and diastolic 99; in June, 1953, the figures were lying, systolic 148, diastolic 92, and standing, systolic 156, diastolic 96.

brother that he suspected that he was suffering from hypertension of any sort; nor had he mentioned the subject to his doctor (Ruskin) nor to his wife.[4]

Appellee urges that the fact that insured took the drug Raudixon sporadically was indicative of the fact that he knew he was suffering from hypertension. The doctors disagreed about the properties of this drug, some considering it primarily a good tranquilizer and only the mildest remedy for hypertension. It was also shown that the insured followed at times a salt poor diet. Such a course was indicated for hypertension, but it was also indicated for loss of weight, which insured was constantly trying to achieve, and for the lessening of the likelihood of recurrence of coronary thrombosis, which was a constant source of worry to him and a logical explanation for much of the proof upon which appellee places the greatest reliance.

If insured was suffering from hypertension, there was ample proof that it was not essential hypertension, that is, chronic or presistent, amounting to a disease; but was occasional hypertension resulting from the fact that he was a tense individual, reacting spontaneously to such stimuli as worry, excitement, frustration. Those closest to him stated that he appeared to be in good health, led a normal life, and did not direct his effort at avoiding strain and tension which would ordinarily be expected of a doctor who suspected that he was the victim of essential hypertension. The foregoing brief analysis demon-

[4]This Court indicated, in the recent case of World Insurance Co., etc. v. Pipes, 1958, 255 F. 2d 464, 467, that the fact that the insured there never told his family or close friends that he had nephritis was strong support for the finding of the trial judge that, if he did have the disease, he did not know it.

strates that reasonable minds would probably reach different conclusions with respect to the questions whether insured had hypertension at all and if so, its character; whether he knew of the condition if it existed and considered it important; whether he deemed it a part of the thrombosis episode and other like questions. That being so, they presented issues of fact and not of law.

The testimony of Dr. Ruskin was of particular importance to appellant. He was a professor in the University of Texas and had written some eighty papers on cardio vascular diseases. He first examined insured in 1949 and continued to see him and confer with him through the years until the end of 1956. He had never found any evidence from his extended examinations that insured had hypertension in any form, and it had never been mentioned to him. While on the stand he told of writing a letter in February, 1955 to American General Life Insurance Company, which is reproduced in the margin.[5]

[5] "American General Life Insurance Company, Houston 1, Texas.

"Attention: Dr. Ghent Graves, Medical Director

Dear Mr. Graves:

Dr. Roosth has been under my care since December 2, 1959, at which time the second EGG sent you was taken. He had a myocardial infarction in August of 1948; was treated in Tyler and recovered uneventfully. At that time G. I. series, gall bladder series barium enema, all negative. I have seen him frequently until June 1954, during this time he has never had any symptoms and his physical examination, including size of heart and fluoroscopy of the heart have always been negative except for blood pressure findings—highest on December 2, 1949, 105/100, but always since then below 140/90. He has taken excellent care of himself, including prolonged anticoagulant thereapy under my direction. Report from Massachusetts Memorial Hospital on June 1943 noted essentially the same findings and EGG (Q2 and Q3). Urinalysis blood counts, sedimentation rates, all normal.

Prompt return of EGGs will be appreciated.

With best regards,
Sincerely yours,
Arthur Ruskin, M.D.
Assoc. Prof. Int. Med.
Univ. of Tex. Med. Br.
Galveston, Texas."

Mr. Balay, underwriter for Lincoln National, admitted that the letter was in Lincoln's file. The letter was submitted to Lincoln by American in connection with insured's application to American for insurance. Lincoln reinsured a great many of American General's risks, and it was the practice of the two companies to exchange information.[6] Mr. Balay also was examined concerning confidential reports made by investigators who had contacted people who were close to the insured and the report showed him to be a man in apparent good health and one who worked regularly.

This letter of Dr. Ruskin's, taken in connection with the underwriter's testimony, would warrant the finding by the jury that the insurer was in possession of facts sufficient to put it upon inquiry at the Massachusetts Memorial Hospital, and that failure so to do would amount to a waiver of the claim that the appellant is barred from recovery by failure of the insured to reveal the examinations made in Boston. At all events, the evidence has persuasive force towards warranting the jury in finding that the insurer did not rely on such failure of the insured to disclose the fact of said examination.[7]

A careful reading of the entire episode involving the examinations by insured in Boston leads to the conclusion

[6]The doctor Ruskin letter referred to an examination at Massachusetts Memorial Hospital in June, 1943, but he explained that this was a typographical error and the date should be 1953. The content of the letter shows that the date is incorrectly stated, because it refers to an examination made after insured's heart attack in 1948.

[7]Perry et al. v. Citizens Life Ins. Co., Ct. Civ. App. Tex., 1942, 163 S. W. 2d 743; Terry et ux v. Texas Prudential Ins. Co., Ct. Civ. App. Tex., 1935, 77 S. W. 2d 761; American Fire & Casualty Co. v. Eastham, 5 Cir., 1950, 185 F. 2d 729; and Pilot Life Ins. Co. v. Pulliam Motor Co., 4 Cir., 1956, 229 F. 2d 912.

that failure to reveal these examinations is not nearly as damaging to appellant's case as the Company contends. At all events, the evidence, considered in connection with the countervailing proof on appellant's behalf, raises nothing more than a jury question on this phase of the case.

Much of what has been written applies to the contention of appellee that the insured gave knowingly false answers to questions 11 and 14 (g) and (h).[1] From what has been said above it is clear that insured did not commit any fraud when he answered that he was not at that time suffering from any disease or disorder.[2]

This brings us to the alleged fraud in answering subparagraphs (h) and (i) of Question 14, asking whether insured had had X-ray, electrocardiogram or blood studies, and whether he consulted any physicians or practitioners the past five years for any other causes. In judging insured's answers to these questions, it must be borne in mind that he had consented to a trial inquiry on November 1st, had signed an application on November 10th, and a subsequent application on December 24, 1956, in all of which he had disclosed his myocardial infarction of 1948 and the fact that the American General Insurance Company had rated him up because of the increased risk resulting from it. Without dispute he had had many electrocardiograms made and had been in constant touch with

[1] It appears that there is no evidence indicating that insured's answer was false when he gave a negative response to the question whether any physician had found his blood pressure above normal within the past five years.

[2] Excepting, of course, the disabilities following the heart attack of 1948, which the court below and all parties except from the questions presented.

Dr. Ruskin and his brother in connection with the aftermath of the 1948 seizure. Dr. Ruskin testified, for instance, that in November or December, 1956, Dr. Young (Lincoln's examiner) and insured telephoned him long distance several times in connection with "a development of immature contractions or extra beats, skips and jumps of his heart which he was concerned about." The doctor did not consider the development of consequence, stating that they frequently occur following myocardial infarctions as well as in cases of perfectly normal individuals "when they are nervous, or exhausted." Manifestly insured had no cause to withhold from the insurer the information that he had consulted these doctors frequently.

Anyone would know that a coronary patient remains heart conscious and is reminded of his disability by the necessity of taking medicine constantly. The form of the questions is such that insured could logically have thought that they referred to his consultation with doctors, causing electrocardiograms to be made, etc., with respect to disabilities other than those connected with the 1948 seizure. At least, the jury was justified in finding that he did honestly so construe the questions, even if they thought that he was mistaken. The seizure of 1948 was an open book and insurer was given opportunity, at its leisure, to make any investigation it desired with respect to it and its consequences and presumably it did so. In judging insured's intent, his answers must be considered from the viewpoint of what was in his mind when he gave them.

But brief consideration need be given to the contentions which appellee urges so fervently, based upon hindsight. These are predicated upon the death certificate issued to cover the demise of insured and the autopsy performed with the consent of appellant. The death certificate furnished by the attending physician of insured showed that the condition directly leading to death was sub-arachnoid hemorrhage and the antecedent causes were ruptured aneurysm due to Circle of Willis. The parties agree that, if the cause of death was that stated in the certificate, there would not be proof that the misrepresentations relied upon were material or that they increased the risk, because supposed hypertension would not be embraced within the cause as certified.

But the Company seeks to avoid the statements of the death certificate, claiming that the autopsy demonstrates that the certificate is in error and that the death resulted from a cause to which hypertension would be a contributing factor. Much of the hardest fighting revolved around this conflict between the death certificate and the autopsy as established by the report and the testimony of the doctor who made it. The Company's witnesses gave their opinions that, if the findings of the autopsy were correct, the insured must have died of hypertension. Appellant's doctors disagreed. Much of the expert testimony of appellee is discounted because the doctor who performed the autopsy admitted that, although he did not find evidence of an aneurysm, there was a possibility and even probability that evidence of its existence had been de-

stroyed by its "explosion."[1] These conflicts were for jury decision.

An extended discussion of the law is not indicated, as appellee concedes in its brief that its defense cannot succeed unless these five elements are proven: "(1) A false representation; (2) in reference to a material fact; (3) made with knowledge of its falsity; (4) and with intent to deceive; (5) with action taken in reliance upon the representation." This accords with the appellant's argument and since all agree that this case is to be decided under Texas law and that, in considering it, we are sitting as a Texas Court, it will be sufficient if we simply list the authorities which establish these principles as the law of Texas."[2]

[1] "I wish to be explicit about this, that I have stated in this autopsy protocal that I did not find an aneurysm. This does not, cannot be taken that there was not one present at one time or another because this hemorrhage which Dr. Roosth suffered was a massive thing which would, I think explosive would be the best word to describe the damage that type of thing can produce. And it is possible and it may be probable that an aneurysm existed and an aneurysm served as the weak spot through which the hemorrhage started and that the entire aneurysm was destroyed and could not be recognized at the time of the autopsy, I would say that is possible, that may be what actually happened."

[2] 14 Vernon's Texas Civil Statutes, Art. 21.16 provides:

"Any provision in any contract or policy of insurance issued or contracted for in this state which provides that the answers or statements made in the application for such contract or in the contract of insurance, if untrue or false, shall render the contract or policy void or voidable shall be of no effect, and shall not constitute any defense to any suit brought upon such contract, unless it is shown upon the trial thereof that the matter or thing misrepresented was material to the risk or actually contributed to the contingency or event on which said policy became due and payable, and whether it was material and so contributed in any case shall be a question of fact to be determined by the court or jury trying such case."

And it is provided in 14 Vernon's Texas Civil Statutes, Art. 21.18:

"No recovery upon any life, accident or health policy shall ever be defeated because of any misrepresentation in the application which is of material fact and which does not affect the risks assumed."

And see Clark v. National Life Insurance Co., 1947, S. Ct. Tex., 200 S. W. 2d 820; Washington National Insurance Co. v. Anderson, C. C. A. Tex., 1936, 94 S. W. 2d 263; Great Southern Life Insurance v. Darfe, 1941, Comm. of App. Tex., 151 S. W. 2d 197; Vann v. National Life and Accident Insurance Co., 1930, Comm. of App., Tex. 24 S. W. 2d 347; and Coxson v. Atlanta Life Insurance Co., S. Ct. Tex., 1944, 179 S. W. 2d 943.

Appellant relies heavily upon the decision of this Court in *Madden v. Metropolitan Life Insurance Co.*, 1943, 138 F. 2d 708. A reading of the case shows that we held that "a representation, though false, does not avoid the policy unless it was made with conscious intent to deceive; that whether it was so made is normally for the jury; and that (even though a question relates to matters of fact such as whether there was a consultation rather than of opinion as to whether insured was ill or suffering from a disease), unless the evidence admits of no other conclusion than that there was an intent to deceive, it is for the jury to determine whether the answer was fraudulent in fact, that is, made with intent to deceive, or whether it was given in good faith, that is, without conscious intent to defraud."

We were there applying the law of Florida as announced in *Metropolitan v. Poole*, 1941, S. Ct. Fla., 3 So. 2d 386. The law of Florida as announced in that case seems to square with the law of Texas. Indeed, as above stated, there seems to be no disagreement between the parties that appellee's affirmative defense must fall unless it proved that insured made false representations to material facts with knowledge of their falsity and with intent to deceive, and that the policy was issued in reliance upon such representations. And these propositions must be established by proof which can lead reasonable minds to only one conclusion. This, we believe, appellee has failed to do.

The contention of appellee that insured was not in good health when the policy was issued and delivered, so that it did not become effective under the terms of the policy, falls under the same analysis of facts as that set forth above in answering the contention that false answers were given in the application.

The burden was upon the appellee to sustain this contention and to show that there was no proof from which the jury could have found that insured was in good health at said time, excepting, of course, the disability under which he labored resulting from his coronary thrombosis. This phase of the law of Texas was discussed in our recent case of *American Home Life Ins. Co. v. Zuniga*, 1955, 228 F.2d 403. Under that case and the Texas cases discussed in it, this question was also one for jury decision.

Appellee labors here under the universally accepted rule that "Fraud is never presumed, and the burden [is] on appellant to prove it with reasonable certainty by a preponderance of convincing evidence."[12] That rule certainly has appropriate application here. The agent seeking to induce appellee to accept Dr. Roosth as its insured represented more than once that he was a prominent and outstanding citizen in his community. Appellee's evidence shows that he was a man of means. A good reputation does not come without effort. It results from adherence day by day to honor and decency and good faith. It ought not to be destroyed by proof which is not clear and convincing. It is a rare case which would justify the finding that, as

[12]Williams v. Penn Mutual Life Ins. Co., 5 Cir., 1928, 27 F. 2d 1, 3.

a matter of law, a man of character has stooped to the cheap fraud relied upon here. We thing that it was error for the judge so to decide. The case, in all of its aspects, should be decided by a jury.

In order that, on another trial, it may be submitted to a jury for decision the judgment of the court below is reversed and the case remanded.

REVERSED and REMANDED.

APPENDIX C

HUTCHESON, Chief Judge, Dissenting:

I agree fully with the majority that in a suit on a policy of life insurance, in order for the defendant to recover, there must be shown: a false representation, in reference to a material fact, made with knowledge of its falsity, and with intent to deceive. I agree, too, that under the controlling statutes and case law, normally these are questions of fact "to be determined by the court or jury trying the case."

As the Texas authorities show, however, while this is normally so, this does not mean that every insurance case must be sent to the jury. On the contrary, it is the established law of Texas that in the trial of such a case, as in the trial of other civil cases, uncontroverted issues are not to be submitted to a jury but are proper subjects for peremptory instructions. Tex. Jur. 41B, Sec. 401, pp. 489-494; *Clark v. National Life & Accident Insurance Co.*, 145 Texas 575; *Jefferson Life v. Quehler*, 298 SW(2) 619.

Under that rule, it seems clear to me that, taken in the light most favorable to the plaintiff, it must be concluded that the evidence incontrovertibly, that is as matter of law, establishes the facts required to support the instructed verdict.

I have not overlooked the fact, of which the opinion makes so much, that the insured was recognized as a substandard risk because of his having had a coronary

thrombosis in 1948. Indeed, I think this fact cuts the other way. Taken in connection with the undisputed evidence that the misrepresented fact was greatly material to, and greatly increased the substandard risk being assumed, the deliberate falsity and materiality of the representations stand starkly out. In short, it seems to me that when this case is viewed, piecemeal or as a whole, in the light of the undisputed facts of the case, including the fact admitted in appellant's brief that the insured "made misrepresentations in his application concerning (1) his failure to report his examination at Massachusetts Memorial Hospial, (2) his failure to report an examination by a physician within the past five years" and that "on these questions defendant would be entitled to an instructed verdict but for the necessity of proving that they concerned matters (1) material to the risk, (2) were made with the intent to deceive, and (3) were relied on.", it is taxing credulity far beyond its utmost limits to contend or claim that what was said and left unsaid was not done knowingly, deliberately, and with the intent to deceive.

It will serve no useful purpose to set out the evidence. The stark facts which dominate this case and force the conclusion that the district judge was right in directing a verdict, including particularly plaintiff's skill and proficiency as a doctor in the very field with which this admitted condition of his had to do, are sufficiently stated in the majority opinion. Cases which I think require the view I take are: *Rhodes v. Metropolitan Life*, 172 F(2)

183; *Pence v. United States, 316 U.S. 332; McDaniel v. United States*, 196 F(2) 29; *United States v. Stratton*, 232 F(2) 880.

I respectfully dissent.

A true copy
Test: /s/ Edward W. Wadsworth
EDWARD W. WADSWORTH
Clerk, U. S. Court of Appeals, Fifth Circuit
New Orleans, Louisiana

(SEAL)

Sep. 29, 1959

APPENDIX D

JUDGMENT.

Extract from the Minutes of July 30, 1959

No. 17426

ROSA LEE ROOSTH,

versus

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY.

This cause came on to be heard on the transcript of the record from the United States District Court for the Eastern District of Texas, and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, reversed, and that this cause be, and it is hereby, remanded to the said District Court for another trial;

It is further ordered and adjudged that the appellee, The Lincoln National Life Insurance Company, be condemned to pay the costs of the in this Court for which execution may be issued out of the said District Court.

"Hutcheson, Chief Judge, Dissenting."

APPENDIX E

ORDER DENYING REHEARING

Extract from the Minutes of September 4, 1959.

No. 17426

ROSA LEE ROOSTH,

versus

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY.

It is ordered by the Court that the petition for rehearing filed in this cause be, and the same is hereby, denied.

"Hutcheson, Chief Judge, Dissenting."

* * * * *